

## GETTING TO KNOW YOU

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Primary phone #: \_\_\_\_\_ Alt. phone #: \_\_\_\_\_

Email: \_\_\_\_\_

Age: \_\_\_\_\_ Gender: \_\_\_\_\_

## WHAT INTERESTS YOU?

Please list any volunteer and life experiences that speak to your interests around mental health.

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## TELL US MORE ABOUT YOU

*Answer each question below in brief essay format as an attachment. Provide your full name on each page, restate the essay question and begin each essay on a separate page. No more than 500 words is needed per answer.*

- A. What are the most pressing mental health issues in your community?
- B. What do you want to gain from participating in Sisters Mentally Mobilized?



## YOUR AVAILABILITY

What times are more convenient for you to attend class (check all that apply)?

Weekday Evenings  Weekends

## HOW ARE YOU SPENDING YOUR TIME?

***Please attach a current copy of your resume.***

Employer: \_\_\_\_\_

Title: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone #: \_\_\_\_\_

Email: \_\_\_\_\_

## YOUR EDUCATION

I am currently enrolled in school as a student:  Yes  No

If yes, Name of School or University:

\_\_\_\_\_

Major and Year:

\_\_\_\_\_



## YOUR SUPPORT SYSTEM

*Please attach a recommendation as a part of your application. The recommendation can be a paragraph, letter or video from a family member, friend or colleague that is familiar with your commitment to mental health or other relevant issues in which you are involved.*

Name: \_\_\_\_\_

Title/Organization: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Primary Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Relationship to Applicant: \_\_\_\_\_

## YOUR COMMITMENT TO THE MOVEMENT

By submitting the application, I am committing to (Please check each box that applies):

- Ensuring the application and information contained herein is true and accurate.
- Completing the program in its entirety and continuing to participate in the movement through sister circles.
- Informing CABWHP if circumstances beyond my control impact my ability to engage in the program as soon as possible so that CABWHP can determine if I should participate at a later time.

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Name of Applicant (please print)



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Signature of Applicant

Date

**Please return this form to Dana Sherrod, Program Manager and Natalie Champion, Senior Program Coordinator by email at [dana@cabwhp.org](mailto:dana@cabwhp.org) and [natalie@cabwhp.org](mailto:natalie@cabwhp.org), or mail at 9800 S. La Cienega Blvd., Suite 905, Inglewood, CA 90301.**

**For additional questions, please call or email Dana Sherrod or Natalie Champion at (310)412-1828.**

